Title: Identifying and retaining HIV-positive women in prenatal care

Health department/organization: Maryland AIDS Administration

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Goals: Linkage to and maintenance of care for HIV-infected women

Program type: Community outreach; case management

Collaborators: Other HIV/AIDS program staff; HIV/AIDS surveillance; other government: non-health department

Background/Objectives

Identifying and retaining HIV-positive women in care requires successful outreach and client advocacy strategies, along with collaboration across multiple agencies and funding streams. HIV-positive women face many barriers to the management of their disease during and after pregnancy. Competing demands for their time and attention include unstable housing, low incomes, and family responsibilities; they often lack childcare and access to information about social and health services. Coordination of clinic services can dramatically improve retention of these women in care and address many of their barriers.

The program goal is to reduce perinatal transmission by addressing the unmet need for HIV primary medical and obstetrical care for HIV-positive women in Baltimore. The program objective is to identify HIV-positive pregnant women and offer them client advocacy services to facilitate continuity of care pre- and post-partum.

Maryland law requires HIV counseling for all pregnant women and voluntary testing. The universal consent form utilizes an "opt-in" approach with nearly 100% acceptance rate among pregnant women in the 3 largest delivery hospitals in the state.

Methods

The University of Maryland (UMB) Hospital serves a large proportion of the HIV-positive women in the state and has one of the largest HIV adult clinics in the state. At the UMB OB/GYN clinic, an outreach worker counsels all pregnant women about HIV testing and tests those who consent. HIV-positive pregnant women are then referred to a client advocate who offers them the full spectrum of HIV health services, including prenatal care, case management, access to the AIDS Drugs Assistance Program, and if eligible, client advocacy, transportation vouchers, psychosocial support services and childcare, if needed. The primary responsibility of the client advocate is to assist the mothers with staying in the care and treatment program. To accomplish this, the client advocate will also visit the mothers in their homes, in prison, in the parent-child clinic, etc. Client advocates close their cases when the mother has attended 3 post-natal HIV primary care visits and is under the care of a case manager.

These services are an integration of CDC prevention and Ryan White services, both managed by the AIDS Administration. Title IV funds provide services to affected family members of the infected women. Treatment adherence and other services are family-centered. Particularly in the case of perinatal infection, the entire family becomes clients as the infant is cared for through the pediatric clinic and then is eventually transitioned to the adolescent and adult clinics. It is the contentions of the clinic staff that this approach helps explain their high client retention rate.

Success is measured by the number of women consenting to an HIV test, the number of HIV-positive women accepting antiretroviral therapy, the number of perinatal infections averted, and the number of women retained in HIV primary medical care after childbirth. Data are reported to the AIDS Administration quarterly.

Results

In 2004 at the UMB site, 178 pregnant women were reached by the client advocate. All of these women consented to HIV testing. Of the 17 who were HIV-positive, all initiated antiretroviral therapy, routine prenatal care and HIV supportive services. Of these,14 were retained in HIV primary care post-partum at that site. One was incarcerated, one was lost to follow-up and another declined to enter care after delivery.

Conclusions

Outreach workers and client advocates have been most effective in identifying HIV-positive pregnant women and assisting them in their care plans. HIV-positive women often need intensive interventions during the pregnancy and in the early post-natal period to successfully manage their HIV disease and reduce the risk of perinatal transmission.

The program has been successful in several ways. First, care coordination among clinic staff provides seamless services. Second, the trained client advocates address women's concerns about housing, substance abuse, etc, instead of focusing only on adherence to appointments and medication regimes. Clients' concerns are examined through a family-centered model and, as appropriate, affected family members are included in care. Finally, clinic administrators have been able to coordinate different grants to offer a wider spectrum of services to the HIV-positive women they serve.

Critical targeting of limited client advocacy and outreach services remain a challenge. Program clients may not be at the highest risk for perinatal transmission because they took the initiative to seek prenatal care. Pregnant women who do not know their HIV serostatus or are aware of their serostatus but are not in prenatal care are at the highest risk for perinatal transmission and other negative maternal/fetal health outcomes. Identifying and reaching these women has previously been attempted through mass media social marketing campaigns and outreach to providers around HIV counseling and testing for pregnant women. However, more can be done to increase the identification of HIV-positive pregnant women not in care.